STATE PLAN OF MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

PROGRAM	LIMITATIONS
12. A. Prescribed Drugs	A. The following are not covered: 1. Non-legend drugs other than insulin, Schedule V cough preparations, family planning products and enteric coated aspirin used in the treatment of arthritic conditions, sole ingredient oral ferrous sulfate products and, for individuals 12 years of age or younger, chewable tablets of iron in combination with vitamins and/or other minerals. 2. Medical supplies and durable equipment, except needles and syringes, family planning supplies and those supplies used in the preparation of compounded prescriptions for home intravenous therapy; 3. Any original prescription dispensed more than 10 days after prescribing date except compounded prescriptions for home intravenous therapy; 4. Drugs supplied to hospital inpatients - (drugs for hospital inpatients are covered under the Hospital Inpatient Program); 5. Drugs and supplies, dispensed by the provider, which are acquired by the provider at no cost; 6. Experimental or investigational drugs; 7. Injectables dispensed by a provider for administration by the prescriber (drugs administered by the prescriber are covered under the Physicians Program) except when authorized by the Department to be covered under the Pharmacy Program; 8. Food supplements or infant formulas; 9. Sugar and salt substitutes;

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
(Continued)	
12. A. Prescribed Drugs	10. Cosmetics, medicine chest supplies and sundries including all soaps, all body powders, all body oils or body lotions, cotton balls, adhesive strip bandages, cotton-tipped applicators, deodorants, dentifrices, tissues, convenience packages of covered items, hot water bottles, ice caps, heating pads, soft cervical collars;
	11. Alcoholic beverages;
	12. Ostomy supplies;
	13. Those services authorized for payment to a prescriber, hospital, nursing facility, hospital outpatient department of free-standing clinic;
	14. Medical Assistance prescriptions and injections for central nervous system stimulants and anorectic agents when used for weight control;
	15. Drug products for which Federal Financial Participation is prohibited pursuant to 42CFR 441.25;
	16. Drug products marketed by a manufacturer or distributor who has not entered into a rebate agreement with the Secretary of the Department of Health and Human Services as described in Section 1903 of the Social Security Act or a manufacturer who has not signed a rebate agreement with the State of Maryland prior to April 1, 1991, except Coverage will be allowed for single source drugs and innovator multiple source drugs if: i. The State has made a determination that the drugs is essential to the health of the beneficiaries;

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
Continued	
12.A. Prescribed Drugs	ii. The drug has been rated as 1-A by the Food Drug Administration (FDA); and
	iii. The authorized prescriber has obtained approval for use of the drug in accordance with the States' prior authorization program as described in D of this Section (Preauthorization Requirements) of the Secretary has reviewed and approved the State's determinations.
	17. Ovulation stimulants for oral or parenteral administration.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
Continued 12.A. Prescribed Drugs Preauthorization Requirements	B. The following are not covered except where preauthorization has been obtained from the Department by the prescriber: 1. Medical Assistance prescriptions or injections for male hormones for biologic females; 2. Medical Assistance prescriptions or injections for female hormones for biologic males; 3. Medical Assistance prescriptions for enteral nutritional products including vitamins and minerals when administered in the home by means of nasogastric, jejunostomy or gastrostomy tube. NOTE: A response to prior authorization requests is provided within 24-hours of the requests. Providers are required to provide at least a 72 hour supply of covered outpatient prescription drug in an emergency situation. C. Limitations to Covered Services: 1. The allowable cost of ingredients dispensed pursuant to a prescription may not exceed an upper limit as established in Attachment 4.19 A & B. 2. Refills: a. The prescriber shall authorize refills on the original prescription.

STATE PLAN OF MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

PROGRAM	LIMITATIONS
Continued 12.A. Prescribed Drugs	b. The Program will authorize no more than two refills; c. Only the original provider may dispense refills; d. A compounded prescription for home intravenous therapy is subject to the following limitations: (i) A prescriber's order is valid for the duration of therapy prescribed, but the duration of a single order may not exceed 100 days; and (ii) All claims submitted require new prescription numbers; 3. The total treatment time covered by the original prescription and its refills, may not exceed 100 days except for: a. Birth control pills which are limited to a 6-cycle supply; b. Oral sodium fluoride products used in the prevention of dental carries are limited to an original prescription of up to 120 days supply with up to two refills, not to exceed a total of 360 days supply. 4. When the drug product is prescribed by its non-proprietary or generic name, the provider shall dispense the least expensive product of equal therapeutic effectiveness available;

STATE PLAN OF MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

PROGRAM	LIMITATIONS
Continued 12.A. Prescribed Drugs	5. Co-Payment (a) There will be a $1 co-payment effective July 1, 1992 by federal category recipients for each covered service, except for the following: (i) Individuals under 21 years old; (ii) Pregnant women; (iii) Institutionalized individuals who are inpatients in long term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs; (iv) HMO enrollees; (v) Family planning drugs and devices. (b) Services cannot be denied to any eligible recipient in a federal category because of the individual's inability to pay the co-payment. A recipient is deemed unable to pay the co-payment if the recipient states to the pharmacist that he or she cannot pay. Pharmacist may not make any inquiry or investigation into the recipient's ability to pay.
Preauthorization Requirements	D. The provider shall obtain preauthorization from the Department or its designee for any prescription for: (1) Maintenance drugs as specified in Pharmacy Services Regulations 10.09.03.05(3)(c), with a usual and customary charge exceeding $100 and a supply for 34 or more days. (2) Antibiotic liquids requiring reconstitution for amounts exceeding a 14 day supply.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations
	(a) Individuals under 21 years old; (b) Pregnant women; (c) Institutionalized individuals who are inpatients in long term care facilities or other institutions requiring spending all but a minimal amount of income for medical costs; (d) HMO enrollees; (e) Family planning drugs and devices. 2. Services cannot be denied to any eligible recipient in a federal category because of the individual's inability to pay the co-payment. A recipient is deemed unable to pay the co-payment if the recipient states to the pharmacist that he or she cannot pay. Pharmacist may not make any inquiry or investigation into the recipient's ability to pay.
Preauthorization Requirements	D. The provider shall obtain preauthorization from the Department or its designee for any prescription for: (1) Maintenance drugs as specified in Pharmacy Services Regulations 10.09.03.05C(3)(c), with a usual and customary charge exceeding $100 and a supply for 34 or more days. (2) Antibiotic liquids requiring reconstitution for amounts exceeding a 14 day supply.

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations
uthorization Requirements tinued)	(3) Non-maintenance drugs for a 34 or more day supply, under extenuating circumstances as determined by the Department or its designee. These prescriptions may not exceed a 100 day supply for the original prescription and any refills. (4) Products with a usual and customary charge exceeding $400 except for home intravenous therapy. E. Preauthorization is not required for: (1) Prescriptions for oral contraceptive drug products; (2) Drugs dispensed in unit dose form to patients in a nursing facility by a provider using an approved unit dose system. F. The pharmacy preauthorization number obtained by a provider from the pharmacy preauthorization program shall be used for the original prescription and up to two refills; not exceeding a total of a 100 day supply. G. A provider shall continue to use the same preauthorization number for subsequent original prescriptions for the same recipient when the subsequent prescriptions are identical to the original prescription and dispensed in an identical manner.
B. Dentures See "Limitations" Item 10, "Dental Services"	

TN No. 91-5

Effective Date July 1, 1990

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
12. c. Prosthetic Devices	1. Prosthetic Devices are reimbursable when supplied as a part of inpatient care necessary to maintain or discharge the patient. For prosthetic devices provided not as part of inpatient care, see Item 19, Medical Supplies and Equipment. 2. Billing time limitations: a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

See Page 9-2

TN No. 91-16
Supersedes
TN No. 86-16

Approval Date _____

Effective Date JAN 28 1991

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

Program	Limitations
12.D. Eyeglasses	A. Limiting covered services to those ordered as a result of a full or partial periodic or interperiodic screen under the EPSDT Program and provided to individuals under 21, the Program places the following specific restrictions upon covered services. 1. Coverage is limited to eyeglasses which have first quality, impact resistant lenses, except in cases where prescription requirements cannot be met with impact resistant lenses, and frames which are made of fire resistant, first-quality material; 2. Subject to item 3, below, coverage is limited to a maximum of one pair per year, unless the time limitations are waived by the Department, based on medical necessity; 3. In order to be entitled to receive eyeglasses, a recipient shall meet at least one of the following conditions: a. The recipient requires a diopter change of at least .50; b. The recipient requires a diopter correction of less than .50 and this has been preauthorized according to section B, below, based on medical necessity; c. The recipient's present eyeglasses have been damaged to the extent that they affect visual performance, or are no longer usable due to a change in head size or anatomy; d. The recipient's present eyeglasses have been lost or stolen. 4. The following are not covered: a. Repairs to eyeglasses; b. Combination or mental frames except when required for proper fit; c. Cost of travel by the provider; d. A general screening of a Medical Assistance population;

TN No. 93-16
Supersedes
TN No.

Approval Date APR 09 1993

Effective Date FEB 16 1993